AGED AND DISABLED WAIVER
CASE MANAGEMENT MONTHLY CONTACT

Member name: Person spoken to: ***Note in comments section below reasons why the Member was not available.***	Medicaid Number:	_____ Face to Face Contact _____ Telephone Contact _____ Quarterly Visit

Questions	**Yes**	**No**	**Discuss the response below (not just yes and no)**
Did you receive the services that were listed on your Service Plan such as bathing, dressing, etc.? *Discuss how you can help.*			
Have you had any concerns with people who come into your home? *Describe and discuss how it can be resolved.*			
Are there times when you needed help and didn't get it? If yes, what happened? *Discuss how to prevent it or a new Crisis Back-up Plan.*			
Have your needs for assistance changed since we last talked? If so, how? *Discuss how.*			
Have you visited a physician, hospital or nursing home as a patient since we last talked? If so, what was the reason for the visit? *Discuss if there is a need for a change in Service Plan*.			
Have you had an incident such as falling? *If so, discuss a risk plan or a way to prevent it.*			
Do you need resources such as medical equipment, food, housing, utilities or medications or help making medical appointments? Discuss it.			
Have there been any changes in your life that affect your need for service *(death, loss, divorce, family member moving, etc.)?*			
If anything happens, do you know how to report problems (services or abuse, neglect or exploitation)? *If not, advise the member.*			
Has there been a change in your phone number or address? *Enter new information in Care Connections.*			
Have you received any letters (DHHR, Social Security or about Medicaid eligibility)?			
Is there any other way I can help you or other things we need to discuss?			

Comments:

By signing, I certify that the reported information is complete and accurate. I understand that payment for the services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under Medicaid Fraud.

_____ _____ _____

Case Manager Signature | Date | Time